when changes in the client's status, responses to treatment, or goal achievement have occurred.

(2) The assessment must be updated no less frequently than every 30 days.

(3) The update must include information on the client's progress toward desired outcomes, a reassessment of the client's response to care and therapies, and the client's goals.

(e) *Standard: Discharge or transfer of the client.* (1) If the client is transferred to another entity, the CMHC must, within 2 working days, forward to the entity, a copy of—

(i) The CMHC discharge summary.

(ii) The client's clinical record, if requested.

(2) If a client refuses the services of a CMHC, or is discharged from a CMHC due to noncompliance with the treatment plan, the CMHC must forward to the primary health care provider (if any) a copy of—

(i) The CMHC discharge summary.

(ii) The client's clinical record, if requested.

(3) The CMHC discharge summary must include—

(i) A summary of the services provided, including the client's symptoms, treatment and recovery goals and preferences, treatments, and therapies.

(ii) The client's current active treatment plan at time of discharge.

(iii) The client's most recent physician orders.

(iv) Any other documentation that will assist in post-discharge continuity of care.

(4) The CMHC must adhere to all Federal and State-related requirements pertaining to the medical privacy and the release of client information.

§ 485.916 Condition of participation: Treatment team, person-centered active treatment plan, and coordination of services.

The CMHC must designate an interdisciplinary treatment team that is responsible, with the client, for directing, coordinating, and managing the care and services furnished for each client. The interdisciplinary treatment team is composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and therapeutic needs of CMHC clients.

(a) *Standard: Delivery of services.* (1) An interdisciplinary treatment team, led by a physician, NP, PA, CNS, clinical psychologist, or clinical social worker, must provide the care and services offered by the CMHC.

(2) Based on the findings of the comprehensive assessment, the CMHC must determine the appropriate licensed mental health professional, who is a member of the client's interdisciplinary treatment team, to coordinate care and treatment decisions with each client, to ensure that each client's needs are assessed, and to ensure that the active treatment plan is implemented as indicated.

(3) The interdisciplinary treatment team may include:

(i) A doctor of medicine, osteopathy or psychiatry (who is an employee of or under contract with the CMHC).

(ii) A psychiatric registered nurse.

(iii) A clinical social worker.

(iv) A clinical psychologist.

(v) An occupational therapist.

(vi) Other licensed mental health professionals, as necessary.

(vii) Other CMHC staff or volunteers, as necessary.

(4) If the CMHC has more than one interdisciplinary team, it must designate the treatment team responsible for establishing policies and procedures governing the coordination of services and the day-to-day provision of CMHC care and services.

(b) *Standard: Person-centered active treatment plan.* All CMHC care and services furnished to clients must be consistent with an individualized, written, active treatment plan that is established by the CMHC interdisciplinary treatment team, the client, and the client's primary caregiver(s), in accordance with the client's recovery goals and preferences, within 7 working days of admission to the CMHC. The CMHC must ensure that each client and the client's primary caregiver(s), as applicable, receive education and training provided by the CMHC that are consistent with the client's and caregiver's responsibilities as identified in the active treatment plan.

(c) *Standard: Content of the person-centered active treatment plan.* The CMHC must develop a person-centered individualized active treatment plan

for each client. The active treatment plan must take into consideration client recovery goals and the issues identified in the comprehensive assessment. The active treatment plan must include all services necessary to assist the client in meeting his or her recovery goals, including the following:

(1) Client diagnoses.

(2) Treatment goals.

(3) Interventions.

(4) A detailed statement of the type, duration, and frequency of services, including social work, psychiatric nursing, counseling, and therapy services, necessary to meet the client's specific needs.

(5) Drugs, treatments, and individual and/or group therapies.

(6) Family psychotherapy with the primary focus on treatment of the client's conditions.

(7) The interdisciplinary treatment team's documentation of the client's or representative's and primary caregiver's (if any) understanding, involvement, and agreement with the plan of care, in accordance with the CMHC's policies.

(d) *Standard: Review of the person-centered active treatment plan.* The CMHC interdisciplinary treatment team must review, revise, and document the individualized active treatment plan as frequently as the client's condition requires, but no less frequently than every 30 calendar days. A revised active treatment plan must include information from the client's initial evaluation and comprehensive assessments, the client's progress toward outcomes and goals specified in the active treatment plan, and changes in the client's goals. The CMHC must also meet partial hospitalization program requirements specified under §424.24(e) of this chapter if such services are included in the active treatment plan.

(e) *Standard: Coordination of services.* The CMHC must develop and maintain a system of communication that assures the integration of services in accordance with its policies and procedures and, at a minimum, would do the following:

(1) Ensure that the interdisciplinary treatment team maintains responsibility for directing, coordinating, and supervising the care and services provided.

(2) Ensure that care and services are provided in accordance with the active treatment plan.

(3) Ensure that the care and services provided are based on all assessments of the client.

(4) Provide for and ensure the ongoing sharing of information among all disciplines providing care and services, whether the care and services are provided by employees or those under contract with the CMHC.

(5) Provide for ongoing sharing of information with other health care and non-medical providers, including the primary health care provider, furnishing services to a client for conditions unrelated to the psychiatric condition for which the client has been admitted, and non-medical supports addressing environmental factors such as housing and employment.

§485.917 Condition of participation: Quality assessment and performance improvement.

The CMHC must develop, implement, and maintain an effective, ongoing, CMHC-wide data-driven quality assessment and performance improvement program (QAPI). The CMHC's governing body must ensure that the program reflects the complexity of its organization and services, involves all CMHC services (including those services furnished under contract or arrangement), focuses on indicators related to improved behavioral health or other healthcare outcomes, and takes actions to demonstrate improvement in CMHC performance. The CMHC must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

(a) *Standard: Program scope.* (1) The CMHC program must be able to demonstrate measurable improvement in indicators related to improving behavioral health outcomes and CMHC services.

(2) The CMHC must measure, analyze, and track quality indicators; adverse client events, including the use of restraint and seclusion; and other aspects of performance that enable the